

# Travel-Associated Febrile Illness Screening Form

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Name of caller: \_\_\_\_\_ Phone # of caller: ( ) \_\_\_\_ - \_\_\_\_

Facility: \_\_\_\_\_

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: ☐ Male ☐ Female If female, pregnant? ☐ Yes ☐ No

If pregnant: EDC: (due date): \_\_\_\_/\_\_\_\_/20\_\_\_\_ LPM (1<sup>st</sup> day of last menstrual period): \_\_\_\_/\_\_\_\_/20\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

County of Residence: \_\_\_\_\_

## Patient Travel History

Country of Travel	From	Until	Purpose of Travel
Other potential exposures: _____			

Date seen by physician: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Symptom onset date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Have symptoms resolved? ☐ Yes ☐ No If yes, when? \_\_\_\_/\_\_\_\_/20\_\_\_\_

## SIGNS AND SYMPTOMS

- ☐ Fever (Highest recorded temperature: \_\_\_\_\_ °F) (Duration of fever: \_\_\_\_\_ days)
- ☐ Myalgia (muscle aches) ☐ Arthralgia (joint aches) ☐ Headache
- ☐ Conjunctivitis ☐ Rash ☐ Rapid, weak pulse
- ☐ Gum bleeding ☐ Blood in vomitus, urine or stool ☐ Vaginal bleeding
- ☐ Epistaxis (nose bleed) ☐ Ascites (fluid in abdominal cavity) ☐ Pleural effusion (fluid on the lungs)
- ☐ Retro-orbital or ocular pain (pain behind the eyes)
- ☐ Age-specific hypotension (low blood pressure)
- ☐ Petechiae (tiny red rash suggesting capillary involvement)
- ☐ Purpura (larger red rash suggesting bleeding abnormality)
- ☐ Ecchymosis (still larger rash; bruising)
- ☐ Other: \_\_\_\_\_

Was patient hospitalized for this illness? ☐ Yes ☐ No If yes, hospital name: \_\_\_\_\_

Admit date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did patient die of illness? ☐ Yes ☐ No If yes, when? \_\_\_\_/\_\_\_\_/20\_\_\_\_

Does the patient have: (check box if yes; leave unchecked if no)

- ☐ Leukopenia (low white cell count) Specify: \_\_\_\_\_
- ☐ Hypoalbuminemia (low protein count) Specify: \_\_\_\_\_ Normal value in your lab: \_\_\_\_\_
- ☐ Hemoconcentration (high red blood cell/hemoglobin) Specify: \_\_\_\_\_
- ☐ Thrombocytopenia (low platelets) Specify: \_\_\_\_\_
- ☐ Hypoproteinemia (low protein) Specify: \_\_\_\_\_

## Any testing done for:

Dengue: ☐ Yes ☐ No ☐ Unknown Chikungunya: ☐ Yes ☐ No ☐ Unknown

Malaria: ☐ Yes ☐ No ☐ Unknown Yellow fever: ☐ Yes ☐ No ☐ Unknown

Influenza: ☐ Yes ☐ No ☐ Unknown Other: \_\_\_\_\_ ☐ Yes ☐ No ☐ Unknown

Previously vaccinated for: ☐ Yellow Fever ☐ Japanese Encephalitis ☐ Tick-borne Encephalitis ☐ Unknown

Additional comments: \_\_\_\_\_

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